AIDS treatment: 30 years of progress

New ideas, analysis and emerging challenges

Sponsored by Gilead
Growing old – the new challenge in HIV treatment

Before the introduction of antiretrovirals in 1996, HIV was considered a death sentence. It is a great achievement that advances in HIV management have enabled people living with HIV (PLWHIV) to have a life expectancy near that of the general population.1 In 2015, one in three people living with HIV in England were aged 50 or over,2 which was unthinkable not long ago. However, this success isn’t without challenges. HIV is associated with increased prevalence of normally age-related comorbidities, including heart disease,3 bone fractures and kidney failure,4 as well as increased risk of cancer.5 With an estimated 84 per cent of PLWHIV over 50 expected to be living with an age-related comorbidity by 2030,7 are we prepared to care for a quarter of PLWHIV over 50 expected to be living with an age-related comorbidity by 2030,8
to the long-term goal of managing the disease. Unless a cure is found, PLWHIV including young people expect to be on HIV medication for the rest of their lives, so it is important that they can access the treatments and care that have the most favourable impact on their health.

Innovation in HIV care is integral to the long-term goal of managing the disease. Unless a cure is found, PLWHIV including young people expect to be on HIV medication for the rest of their lives, so it is important that they can access the treatments and care that have the most favourable impact on their health.

The rise and fall of AIDS patient empowerment

Campaigning groups must work together to repeat the successes of the past, writes Harry Quilter-Pinner, research fellow at the Institute for Public Policy Research

On 5 June 1981, a medical journal in the US reported a mysterious illness that had killed five young gay men in LA. Gay Related Immune Deficiency, as it became known, was first diagnosed in the UK soon after. Fuelled by prejudice, and in spite of the scale of the crisis, government and industry were slow to react. The UK’s then solicitor general said “too many people have strayed so far and so often from what we are taught is normal moral behaviour”, while Manchester’s chief constable described AIDS patients as “swirling in a human cesspit of their own making”.

In the face of this ignorance, fear and hatred, the LBGT+ community began to stand up to the disease themselves with a network of campaigning organisations such as ACT UP, the AIDS Coalition and Unleash Power. These new organisations raised awareness and campaigned for better access to healthcare, more research and quicker access to new treatments. From an inauspicious start they quickly became experts, contributing to major victories such as the inclusion of patients in the research process, the earlier introduction of lifesaving drugs and the creation of public health campaigns.

Then came antiretroviral drugs, and with them what one scientist called “the Lazarus effect... People who were in hospitals on their last breath are getting up and going to work”. Today people with HIV (in the West, at least) can expect to live a near normal life, thanks in part to the AIDS activists who catalysed a rethink of where power should lie in health systems. Today, the idea that “patient empowerment” should be a feature of health services is not controversial. In theory, a patient with a long-term condition in the NHS should now have a high level of engagement in where and how they are treated, with support from peer groups and courses on managing their care.

However, the reality is that only five per cent of patients with a long-term condition have been given a care plan. Seven per cent have been offered ways of connecting with fellow patients, and nine per cent have had educational support. The mechanisms of patient activation are on the wane.

Breakthrough treatments that could transform the lives of patients across the country are being rationed by the NHS, and new technologies that could allow patients to manage their care remotely are not being adopted.

Why is this happening? This time it’s not institutionalised prejudice at fault, but it’s hard not to see a link between austerity and a return to the default position which sidelines patient involvement. The overriding priority has become cost containment, with the patient empowerment agenda taking a back seat.

The trends that have been described in this article – an underfunded health service, breakthrough new treatments and models of care, and disempowered patients – are a toxic trio. Together, they create a significant risk that the system will fail to keep up with what is scientifically and technically possible, leading to an unnecessary slowdown in the progress made in terms of peoples’ quality and quantity of life.

Whether this drives the reemergence of patient activism, as seen in the 1980s and 90s amongst those suffering from AIDS, is open to debate. The fear is that the circumstances that gave rise to the AIDS movement at that time are unlikely to be replicated. This time, it won’t be one group that suffers in isolation – which, however awful, tends to bring that group together to oppose the status quo – but everyone who uses our health and care system.

The choice we all face is whether we sleepwalk into a decade of deterioration, or form coalitions to demand a health service fit for the next century.
Three decades of AIDS treatment

1985
HIV testing is introduced in the UK

1988
World AIDS Day is established

1992
The first combination drug therapies for HIV are announced

1995
Highly active retroviral treatments are introduced
Widespread sustained viral suppression is achieved for the first time

101,200
people in the UK are living with HIV
13 per cent of people with HIV are unaware of their infection
Cities can lead on AIDS treatment

Cities bear a large share of the global HIV burden. Cities are home to large numbers of people belonging to key populations at higher risk of HIV infection, as urban populations continue to rapidly grow, cities will contend with growing HIV epidemics if urgent and effective action is not taken.

Since its World AIDS Day 2014 launch, Mayors and other municipal leaders have joined forces with civil society representatives to action the Paris Declaration on Fast Track Cities. The International Association of Providers of AIDS Care (IAPAC), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Human Settlements Programme (UN-Habitat), and the City of Paris are supporting Fast Track Cities to achieve the following targets by 2020:

- 90 per cent of people living with HIV (PLHIV) knowing their HIV status
- 90 per cent of PLHIV who know their HIV-positive status on antiretroviral therapy (ART)
- 90 per cent of PLHIV on ART achieving viral suppression
- Zero stigma and discrimination

The 90-90-90 targets focus on the political commitment to build services and support to ensure access to HIV testing for everyone living with HIV. However, diagnosing people with HIV is not enough and the 90-90-90 targets also emphasize ensuring access to early ART and long term viral suppression as a means to keep people healthy and prevent HIV transmission.

HIV prevalence is more than twice as high in London as it is in England. Two in five people with HIV in the UK live in London. HIV disproportionately affects some minority communities, particularly gay men, transgender people and black Africans.

Sadiq Khan, the Mayor of London, has signalled in his draft “health inequalities strategy” the “opportunities to use the profile of City Hall to challenge HIV stigma and to promote international learning and collaboration to reduce the impact of HIV in London. The UNAIDS Fast Track Cities initiative may be one way to help bring HIV under control.”

Khan’s health inequalities strategy also highlights HIV inequalities. “There is wide variation in the rate of late diagnosis among London’s boroughs and demographic groups”, it reads. “In 2015, black African people were more than twice as likely as white people to be diagnosed late.”

Key to attaining the 90-90-90 and zero stigma is people-centred HIV care, including care that meets the needs of different groups of people living with, or at high risk of acquiring, HIV, including gay men, members of the trans community and people of black and minority ethnic heritage.

The Fast Track Cities programme is one way of contributing to ending AIDS as a public health threat by 2030. Across Europe a number of cities, including Paris, Amsterdam, Milan, Bucharest and Geneva have signed up to achieve the 90-90-90 targets and to end stigma of people living with HIV. With the support of Sadiq Khan it is hoped that London will also become a Fast Track City and that City Hall will lead collaborative efforts with London’s health and public health systems to work towards international targets for HIV prevention and treatment.

GOALS FOR THE FUTURE
WILL LONDON BE THE NEXT FAST-TRACK CITY?
Scaling up HIV treatment in the third world

A look at the processes that have brought medication to ten million people in developing countries

It has been more than three decades since the first cases of AIDS were reported and we have seen great progress since. One thing, however, has remained constant and crucial to HIV: access to medicines. Gilead’s medicines have helped transform HIV infection from a debilitating and fatal disease into a manageable condition for many. We remain committed to the continued development of new therapies for individuals who live with the disease, regardless of treatment status or age. We are equally committed to making those medicines available to all patients, regardless of geography or economic circumstance as quickly as possible.

The Gilead model for HIV treatment provision in developing countries has evolved over time, in response to lessons learned, stakeholder feedback and evidence. Today, more than ten million of those being treated for HIV in the developing world receive Gilead medicines. Gilead’s first antiretroviral access programs were based closely on the company’s commercial operations in developed countries, but did not take account of the unique challenges facing drug delivery in resource-limited settings. The access model has come a long way since then, driving year-on-year growth in the number of patients receiving Gilead HIV medicines in low- and middle-income countries.

Through access programs, including voluntary licensing and partnerships with generic manufacturers, our medicines are now available in more than 130 lower-income countries at affordable prices. In 2016, the Access to Medicine Index recognized Gilead as a leader in improving access to medicine in developing countries.

In developing countries, generic licensing – in which patent holders grant licenses that allow another drug company to manufacture a generic version of their drug – has helped transform treatment access, providing high-quality, low-cost drugs. Of the 17 million people with HIV in developing countries receiving treatment today, more than 10 million receive therapies developed by Gilead. The vast majority of these are in generic form, supplied as a result of Gilead’s licensing agreements. These licensing agreements were established in 2006 when Gilead recognised that it did not, on its own, have sufficient capacity to meet global needs for HIV treatment in a cost-effective manner. Licensor were therefore allowed to produce generic versions of Gilead’s HIV therapies in 16 low- and middle-income countries. Partners set their own prices and may also create fixed-dose combinations with other HIV medicines. Partners receive a full technology transfer of the Gilead manufacturing process, enabling them to quickly scale up production to meet the enormous demand.

In July 2011, Gilead also became the first innovator pharmaceutical company to sign an agreement with the Medicines Patent Pool (MPP), an international organization that expands access to medicines through the sharing of drug patents. Yet generic licensing is only one part of the solution to a highly complex challenge. “Tiered” or “differential” pricing is used regularly in the pharmaceutical industry. The idea is simple enough: prices are set for countries according to their economic situation, as determined by their varying level of national income. However, Gilead looks not only at the purchasing power, but also considers other factors such as disease burden, treatment needs, and healthcare infrastructure to help shape the company’s thinking. In the majority of developing countries Gilead has set a flat price for its medicines which result in little or no profit to the company.

Even though these approaches may address the cost of medicines, they don’t address the other barriers to access to care. In many middle- and low-income countries, health systems have suffered from decades of under investment and a high proportion of people having to pay for healthcare out of their own pocket, leaving the most vulnerable populations unable to access life-saving treatments even when those medicines are available at a low cost. Some countries also do not have enough trained health workers, or lack robust regulatory systems to quickly approve and regulate the use of new drugs. That’s why companies such as Gilead work with governments, non-profit organizations and communities to build the programs, capacity, and expertise needed to overcome the complex barriers to access. Let’s not forget that despite enormous progress in the global HIV treatment response, 10 million people living with HIV still don’t receive life-saving medicines.

Innovator pharmaceutical companies, ministries of health and finance, health-care professionals, non-profits, generic manufacturers, researchers, and community organisations will all have important roles to play in reaching those patients in need.
Stigma, access to treatments and a sense that HIV is “sorted” are far too common issues faced by people living with HIV and AIDS.

There are many things still to be done. The spirit and the message of World AIDS Day drive Gilead every day to do more in the fight against HIV.

**Gilead is committed to -**

- Innovating in HIV treatment.
- Ensuring broad access to our medicines.
- Supporting HIV prevention.
- Working in collaboration with people living with HIV/AIDS, government and policy makers to tackle the challenges faced by people living with HIV.

With an estimated 36.7 million people worldwide living with HIV, World AIDS Day is an important reminder that our work is far from over.

1. Global Health Observatory (GHO) data, 2016

[Map of the world with red ribbons]

[Logo of Gilead]